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Dental Expense Benefits

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan.

The following dental expense benefits will apply to you only if you have elected such coverage by returning your signed form in accordance with the enrollment procedures of this Plan.

This section explains the main features of the Plan. It is not complete without the corresponding "Summary of Coverage."

Booklet Base: Dental
Issue Date: August 24, 2006
Effective Date: September 1, 2006

Summary of Coverage

Employer: The Department of Defense
Nonappropriated Fund Health Benefits Program

ASC: 721027 (Continental US Benefits Participants)
724872 (Overseas Aetna Global Benefits Participants)

SOC: Dental

Issue Date: August 25, 2006

Effective Date: January 1, 2006 721027 (Continental US Benefits Participants)
September 1, 2006 724872 (Overseas Aetna Global Benefits Participants)

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Your Coverage

You are in an Eligible Class if you are enrolled in a Department of Defense Nonappropriated Fund medical plan (including an HMO that does not have a dental rider) and are:

- a Regular Full-Time (RFT) or Regular Part-time (RPT) civilian employee scheduled to work at least 20 hours per week, who is paid on the U.S. dollar payroll, and who is a U.S. citizen or resident alien living in the United States, the District of Columbia, Puerto Rico or Guam, or

- a Retiree who is eligible to continue participation in the Department of Defense Nonappropriated Fund Health Benefits Program. To be eligible for post-retirement dental coverage, you must also be enrolled in a dental plan associated with the Program on the day before retirement and have 15 years of creditable participation in the dental plan. Your employer can provide more detailed information about these requirements.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you become part of an Eligible Class.

The following groups are not in an Eligible Class:

- Flexible employees
- Foreign Nationals
- Resident Aliens living outside of the U.S.
  (unless he or she is a military spouse accompanied by a sponsor stationed at a location outside the United States).

Dependents

- **You may cover your:**

- **wife or husband, including a common-law wife or husband in those states that recognize common-law marriages.**
- **unmarried children under 19 years of age.**

- **unmarried children under age 25 who are full-time students in actual attendance at an accredited educational institution, are not working on a regular full-time basis, and depend on you for support.**

- **any child over the maximum age who is determined to be incapable of self-support due to a handicap. Proof of handicap must be submitted to Aetna no later than 31 days after the maximum age is reached. See Child With Disabilities section.**

Your children include:

- Your biological children.
- Your adopted children.
- Your step children who either live with you or are dependent upon you for support.
- Any other child who is not your biological, adopted, or step child, but who lives with you and is dependent upon you for financial support. Evidence proving dependency is required in the form of documentation of legal guardianship or inclusion of the child on your income taxes.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Your enrollment packet will include a form to complete. Enrollment in the plan may be processed electronically (for the NAF services with health benefits electronic capabilities) or with an enrollment form. This form will allow your Employer to deduct your contributions from your pay to cover your contributions for the plan you elect during enrollment.

IMPORTANT! You must sign, date and return the completed enrollment form to your Human Resources Manager **WITHIN 31 DAYS** of your Eligibility Date for you and your dependents to be covered. Your Human Resource Office representative will sign and date the enrollment form to acknowledge receipt. **If you don't sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you may not elect Dental Expense Coverage until the next open enrollment period established by your Employer. If you enroll electronically (for the NAF services with health benefits electronic capabilities), your enrollment must be processed within 31 days of your Eligibility Date.**

If you want DEPENDENT coverage for a newly eligible dependent (for example, you get married or have a baby), complete a new enrollment form (available from your Human Resources Manager) or process electronically (for the NAF services with health benefits electronic capabilities) within 31 days of the Eligibility Date (i.e. date of marriage or baby's date of birth). When you elect DEPENDENT coverage, you must list all their names on the appropriate section of the enrollment form. **If you do not request DEPENDENT coverage within 31 days of the Eligibility Date, you may not elect Dental Expense Coverage for such dependent until the next open enrollment period established by your Employer.**

Effective Date of Coverage

Your Coverage

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed group coverage enrollment form to your Human Resource Manager or the date your enrollment is processed electronically.

If you do not sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you will not be able to elect coverage until the next open enrollment period established by your Employer.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions.

If you have EMPLOYEE COVERAGE ONLY and you request DEPENDENT coverage for a *newly eligible* dependent **within 31 days** of their Eligibility Date, the effective date of DEPENDENT coverage is the date of the election.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits the election of coverage until the next open enrollment period will not apply to a child who meets the definition of a dependent and for whom you are required to provide dental coverage as the result of a qualified medical child support order (QMCSO). Upon receipt of a QMCSO, coverage of the child is not optional; your employer is required to enroll the child in the plan whether you request the enrollment or not. This coverage is mandated by the terms of the QMCSO. If your enrollment in the plan is required in order to provide dental coverage for the child, your employer will also enroll you. Coverage will be effective on the date of the court order. If you are currently not enrolled and are eligible for coverage in the dental plan, your employer will enroll you and your dependent(s) for family coverage as of the date on the court order.

If you are the non-custodial parent, proof of a dental benefit claim for the dependent child may be given by the custodial parent. Benefits for a claim will be paid to the custodial parent.

Dental Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Comprehensive Dental Expense Coverage

Calendar Year Deductible The Calendar Year Deductible applies to all expenses except: Type A Expenses Type B Oral Surgery Expenses only Orthodontic Expenses TMJ Treatment Expenses	$ 100
Family Deductible Limit	$ 300
Payment Percentage	
Type A Expenses	100%
Type B Expenses	80%
Type C Expenses	50%
TMJ Treatment Expenses	50%
Oral Surgery Expenses	100% of the first $1,000, then 80% thereafter
Orthodontic Treatment Expenses	50%
Calendar Year Maximum* *Not applicable to Oral Surgery Expenses and Orthodontic Treatment Expenses	$ 2,000
Orthodontic Lifetime Maximum	$ 1,500
Temporomandibular Joint Dysfunction/ Myofascial Pain Dysfunction (TMJ) Lifetime Maximum	$ 750

All expenses are subject to Reasonable Charge limits as explained in this Booklet.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of dental benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Dental Expense Coverage

Dental Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in the "Benefits After Termination Coverage" section, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. **It applies even if there is a break in coverage.**

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be $ 200 or more, it is strongly recommended that details of the proposed course of treatment and charges to be made be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts. An Advance Claim Review is not required, but it is beneficial to you because it will let you know in advance how much the Plan will pay for your treatment.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage:

- of Type A expenses; and
- of Type B expenses; and
- of Type C expenses; and
- Oral Surgery Expenses.

The benefit payable for charges made by a **Preferred Care Provider** is an amount equal to the Payment Percentage of the **negotiated charge** for the service or supply, after the applicable **Preferred Care** deductible.

The benefit payable for charges made by a provider that is not a **Preferred Care Provider** is an amount equal to the Payment Percentage of the provider's charge for the service or supply, after the applicable **Non-Preferred Care** deductible.

The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. You are responsible for the deductible.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- **reasonable** and **necessary**; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

The Dental Expenses listed below will not be included as Covered Dental Expenses if they are covered in whole or in part:

- elsewhere under this Plan; or
- under any other plan of group coverage provided by or through your Employer.

Alternate Treatment

If alternate services or supplies may be used to treat a dental condition, Covered Dental Expenses will be limited to those services and supplies which:

- are customarily used nationwide for treatment; and
- are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person's total current oral condition will be taken into account.

The Limitations section has some examples of how this works.

Type A Expenses

100%-These expenses are not subject to the Dental Calendar Year Deductible

- Oral exams twice per calendar year. This includes prophylaxis, scaling and cleaning of teeth.
- Topical application of sodium or stannous fluoride for persons under 15 years of age.
- X-rays for diagnosis. Also other x-rays not to exceed one full mouth series in a 36 month period and one set of bitewings in a 6 month period.
- Dental sealants of the permanent bicuspids and molars for persons under 18 years of age, not to exceed one sealant per tooth in any three year period.

Type B Expenses

80%-These expenses are subject to the Dental Calendar Year Deductible

- Space maintainers for persons under 19 years of age.
- Extractions.
- Fillings (except gold fillings).
- General anesthetics given in connection with covered dental services.
- Treatment of diseased periodontal structures.
- Endodontic treatment. This includes root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, inlays, bridgework or dentures.
- Relining of dentures. This service is covered at 36 month intervals. Separate intervals apply for upper and lower dentures.
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed.
- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. But, the "Prosthesis Replacement Rule" below must be met.

Type C Expenses

50%-These expenses are subject to the Dental Calendar Year Deductible

- Inlays, gold fillings, or crowns. This includes precision attachments for dentures.
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met.

The following services and supplies required for treatment of temporomandibular joint dysfunction or myofascial pain dysfunction:

- Diagnostic oral examinations and x-rays.
- Restorative procedures to alter occlusion.
- Auto repositioning appliances.
- Joint manipulation and other physical therapy involving structures of the jaw.

The aggregate benefit payable for all treatment of temporomandibular joint dysfunction or myofascial pain dysfunction rendered to a dependent during his life will not exceed the Temporomandibular Joint Dysfunction/Myofascial Pain Dysfunction (TMJ) Lifetime Maximum regardless of any interruption in coverage.*

*TMJ expenses are not subject to the calendar year deductible, but are subject to the TMJ Lifetime Maximum of $750.

Prosthesis Replacement Rule
Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. But proof satisfactory to Aetna must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.

- The present denture or bridgework cannot be made serviceable. Also, it must be at least 5 years old.
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

Oral Surgery Expenses

100% for the first $1,000; 80% thereafter - These expenses are not subject to the Dental Calendar Year Deductible

- Oral surgery expenses that are dental in nature.

Special Provisions For Orthodontic Treatments

A **dentist's** charges for services and supplies for **Orthodontic Treatment** are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for Orthodontic Treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

Have your **dentist**/orthodontist submit a claim form providing the **Orthodontic Treatment** plan. This should include the type and length of treatment; the total case fee, and the date bands were placed. Using that banding date, an initial installment allowance of 25% of the total case fee (up to the negotiated fee for a **Preferred Care Provider** or the **Reasonable Charge** for a non-participating provider) will be considered for payment at 50%. The remaining 75% of the total case fee will be prorated over the length of treatment and automatically reimbursed on a quarterly basis at 50% up to the Orthodontic Maximum. If coverage is terminated, benefits will be allowed through the last month of active coverage.

Example One:
Coverage through completion of Orthodontic Treatment Plan

Orthodontic Treatment Plan	
Total Case Fee:	$4,000
Negotiated Fee:	$3,000 (Orthodontic Maximum: $1,500)
Length of Treatment:	15 months
Date Banded:	03/01/06
Negotiated Fee Breakdown	
Initial Fee:	$750 (25% of $3,000)
Monthly Fee:	$150 ($3,000 - $750 = $2,250; $2,250/15 months)
Quarterly DOD NAF HBP Fee	$450 ($150 x 3)
Calculation of Payment	
Initial Payment:	$375 (50% of $750)
Quarterly DOD NAF HBP Payments:	$1,125 (50% of $450/per Quarter x 5 Quarters)
Total DOD NAF HBP Orthodontic benefit for this claim:	$1,500 ($375 + $1,125)

Example Two:
If coverage terminates prior to completion of Orthodontic Treatment Plan

Termination Date:	08/03/06
Orthodontic Treatment Plan	
Total Case Fee:	$4,000
Negotiated Fee:	$3,000 (Orthodontic Maximum: $1,500)
Length of Treatment:	15 months
Date Banded:	03/01/06
Negotiated Fee Breakdown	
Initial Fee:	$750 (25% of $3,000)
Monthly Fee:	$150 ($3,000 - $750 = $2,250; $2,250/15 months)
Quarterly DOD NAF HBP Fee	$450 ($150 x 3)
Calculation of payments	
Initial Payment (March 2006):	$375 (50% of $750)
1st Quarter (April, May, June 2006) DOD NAF HBP Orthodontic Payment:	$225 (50% of $450)
July and August 2006 DOD NAF HBP Orthodontic Payment:	$150 ($150 x 2 = $300; 50% of $300)
Total DOD NAF HBP Orthodontic benefit for this claim:	$750 ($375 + $225 + $150)

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Limitations

When the Alternate Treatment part of this Plan applies, benefits will be limited. Some examples of how this works follow.

Restorative

Gold, Baked Porcelain, Crowns, and Jackets. Covered Dental Expenses will be limited to the charges for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the **dentist** choose some other type of restoration.

Reconstruction. Covered Dental Expenses will be limited to the charges for the procedure needed to eliminate oral disease and replace missing teeth. Appliances or restorations needed to increase vertical dimension or restore the occlusion are deemed to be optional. They are not covered.

Prosthodontics

Partial dentures. Covered Dental Expenses will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the **dentist** choose a more elaborate or precision appliance.

Complete dentures. Covered Dental Expenses will be limited to the charges for a standard procedure. This limit applies even if you and the **dentist** choose personalized or specialized treatment.

Replacement of existing dentures. This will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, Covered Dental Expenses will be limited to the charges for the services needed to make the denture usable.

Exclusions

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Treatment by other than a **dentist**. But the Plan will cover some treatments by a licensed dental hygienist that are supervised by a **dentist**. These are scaling of teeth, cleaning of teeth and topical application of fluoride.
- Services or supplies that are cosmetic in nature. This includes charges for personalization or characterization of dentures.
- The replacement of a prosthetic device that is lost, missing or stolen.
- Any services or supplies which are for orthodontic treatment, except as specifically provided.
- Services or supplies to increase vertical dimension. These are dentures, crowns, inlays and onlays, bridgework or any other appliance or service.
- Any services or supplies which are for treatment of temporomandibular joint dysfunction or myofascial pain dysfunction except as specifically provided under Type C Expenses.
- Analgesia, Anxiolysis, Inhalation of Nitrous Oxide and Local Anesthesia except when billed as part of a covered procedure.

Benefits After Termination of Coverage

Dental services given after the covered person's coverage terminates are not covered. However, ordered dentures, fixed bridgework and crowns will be covered when ordered, if the item is installed or delivered no later than 60 days after coverage terminates.

"Ordered" means:

- impressions have been taken from which the dentures, crowns, or fixed bridgework will be made; and
- as to fixed bridgework and crowns; the teeth must have been fully prepared if:

  they will serve as retainers or support; or

  they are being restored.

General Exclusions

General Exclusions Applicable to Dental Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is dental coverage.
- Those that a covered person is not legally obliged to pay.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for charges for failure to keep an appointment.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have group health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits.
For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by
"other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

   If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:

   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claims transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. A "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plans

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare (Part A and Part B)" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare (Part A and Part B) benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases. Ceasing active work will be deemed to be cessation of employment.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Continuation of Coverage For Surviving Dependents

If you die as an active employee covered under any part of this Plan, and had completed a minimum of 90 days of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan, and if your dependents are enrolled as a dependent in the Plan on the day preceding your death, any Dental Expense Coverage then in force for your dependents will be continued at no cost to them for the first four months following your death.

If at the time of your death you had completed a minimum of 90 days, but less than 15 years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan or were not participating in your Employer's defined benefit retirement plan, any dependent's coverage, including coverage for your spouse, will cease at the end of the four month period right after your death.

If at the time of your death you had completed 15 or more years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan, and were participating in an applicable defined benefit retirement plan, surviving dependents will be required to make contributions toward the cost of their coverage equal to the contributions then being charged to active employees for like coverage. Dependents acquired by your surviving spouse upon remarriage are precluded from coverage.

Under the above sections, any dependents' coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.

If Dental Expense Coverage is being continued for your dependents, your child born after your death will also be covered. The completed enrollment form must be returned to your Human Resources Manager within 31 days of the date the child is born.

Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

Children With Disabilities

Dental Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Assignments
Coverage may be assigned only with the written consent of Aetna.

Recovery of Overpayment
If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting of Claims
A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the expense. You may obtain claim forms through your Employer or through Aetna Member Services.

Members are encouraged to file their claims within 90 days after the date the claim was incurred. This will insure sufficient time should the claim be disputed or if additional documentation of the services provided is needed for claim processing.

If, through no fault of your own, you are not able to file your claim within 90 days of the date it was incurred, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years and 90 days after the date the claim was incurred.

Payment of Benefits
Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

This Plan may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses
Keep complete records of the expenses of each person. They will be required when claim is made.

Very important are:

Names of **dentists** who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory can be requested by calling the Member Services number on the front of your ID card. A listing of the Preferred Care Providers is also available at the Aetna DocFind® internet website. The Aetna internet home page address is listed on the back of your ID card.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Orthodontic Treatment
This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Parent-Child Relationship
A parent-child relationship exists between you and a child when the child is primarily dependent on you for support and the child is:

- unmarried;
- resides in the same household as you;
- has not reached the limiting age of the plan; and
- if school age and regularly attending school, resides primarily in your home.

When a natural parent lives in the same household, a parent-child relationship exists between you and a child only when both the natural parent and the child are primarily dependent upon you for support and the natural parent as well as the child meet the IRS dependency tests.

Physician
This means a legally qualified physician.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Student

A student is one who;

- attends school regularly on a full-time basis;
- is not employed full-time (i.e. working 7-8 hours a day, 5 days a week); and
- attends a school which:

  is an institution which offers a regular schedule of courses on an annual or more frequent basis;

  has a full-time faculty and a permanent administration; and

  includes some formal classroom sessions rather than just on-the-job training.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). You are eligible for FMLA if you have at least 12 months of service for your Employer. An eligible employee is entitled to 12 administrative workweeks of unpaid leave during any 12 month period for specified family and medical needs.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Dental Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, and still want coverage, you will need to enroll in the Plan during the next Open Enrollment Period.

Claims Appeals For Dental Expense Benefits

Claims Procedures For Dental Expense Benefits

This booklet contains information on reporting claims. Claim forms may be obtained at your place of employment or through Aetna. These forms tell you how and when to file a claim.

Benefits under this plan will be paid only if the plan administrator decides in his/her discretion that the applicant is entitled to them.

If your claim is denied in whole or in part, you will receive a written notice of the denial from your Claim Administrator, Aetna Life Insurance Company. The notice will explain the reason for the denial and the appeal procedures.

Filing Dental Claims under the Plan

You or your authorized representative may file claims for Plan benefits, and appeal adverse claim decisions. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a dental care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claim

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed.

If the Plan requires advance approval of a service, supply or procedure before a benefit is payable and it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Pre-Service Claim

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

Post-Service Claims

For all other claims, you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period and advised of any additional information that is needed to process the appeal. You will be notified of the Plan's claim decision no later than 15 days after receipt of the necessary information or the end of 45 days, whichever is earlier.

Filing an Appeal of an Adverse Benefit Determination

Level I Appeal

You have the right to file an appeal of an adverse benefit determination. An appeal must be received within one hundred and eighty (180) calendar days of notification of an adverse benefit determination in order to be considered. Aetna will notify you of the appeal decision in the following timeframes:

Urgent Care Claim – 36 hours
Pre-Service Claim – 15 days
Post-Service Claim – 30 Days

Level II Appeal

If you are dissatisfied with the level I appeal decision, you have the right to file a level II appeal. You have 60 days to submit an appeal of the Level I decision. Aetna will notify you of the appeal decision in the following timeframes:

Urgent Care Claim – 36 hours
Pre-Service Claim – 15 days
Post-Service Claim – 30 Days

Appeal to the Plan Sponsor After Level I and Level II Appeals

The member has 30 days to submit an appeal to the Plan Sponsor. The Plan Sponsor has final authority after Level I and Level II Appeals to Aetna have been exhausted.

This information is provided to you by your employer. This claim appeal information is being provided as an aid to you in keeping claim material related to dental coverage together. If you have any questions or problems, please call the 800 number on your ID card.